to discontinue medication, regarded as unnecessary around the perioperative period, that is not later restarted.[4]

Atherosclerosis is a chronic progressive disease and, while surgical revascularisation can improve a patient's clinical condition, the consequences of subsequent disease progression should be recognised and patients should be offered all available preventive measures to reduce heart attack, stroke, and other cardiovascular events.

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IMAGES IN CARDIOLOGY

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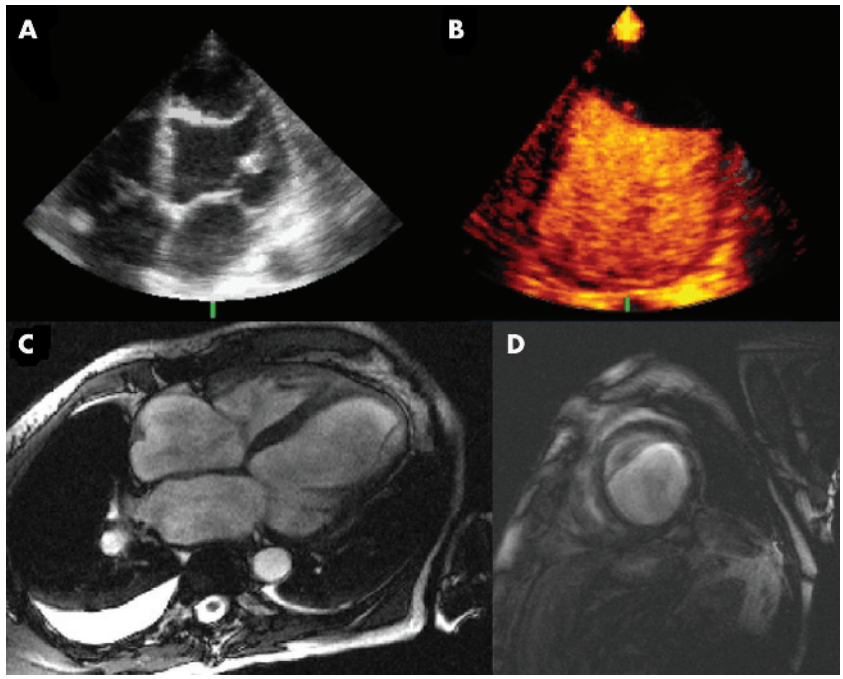
Intramyocardial dissecting haemorrhage and multiple left ventricular thrombus formations in subacute myocardial infarction and antiphospholipid syndrome

A 68 year old man was admitted complaining of chest discomfort and severe dyspnoea. During the preceding month he was admitted to a neurological department with a generalised epileptic crisis. Brain magnetic resonance imaging (MRI) demonstrated ischaemic lesions in the region of the right medial cerebral artery.

Clinical evaluation revealed signs of biventricular heart failure. An ECG showed sinus rhythm and left bundle branch block. Laboratory evaluation was notable for a positive antiphospholipid syndrome (anticardiolipin antibodies and lupus anticoagulants positive), and revealed also the following pathological findings: platelets 62 000/mm^3; international normalised ratio (INR) 1.7; creatine kinase (CK) 461 U/l; CK-MB 115 U/l; troponin T 0.03 µg/l; factor VIII 399%. Transthoracic echocardiography (TTE) showed left ventricular (LV) enlargement, severe dysfunction, and spontaneous echo contrast; a large echo-free neocavitation involving the LV apex, clearly delimited by endocardium towards the middle portion of ventricular cavity, was detected. In the basal inferior wall a thrombus formation was seen. Myocardial contrast echocardiography demonstrated no opacification in the apical neocavitation with incomplete perfusion of the endomyocardial border (panels A and B). These findings suggested an intramyocardial dissecting haemorrhage formed after subacute myocardial infarction. Further assessment was performed using cardiac MRI and confirmed the diagnosis of an apical intramyocardial haematoma (panels C and D).

The patient underwent coronary angiography that revealed severe three coronary vessel disease, indicating the need for coronary artery bypass graft surgery. Follow up showed spontaneous retraction of the dissecting haematoma and persistent basal thrombus. The pre-surgery TTE revealed recent thrombus formations in the left ventricle, despite intravenous heparin treatment. Heart surgery was performed and the patient was subsequently discharged.



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